

Interdisciplinary Team CCB Documentation and Service Agreement

Waiver Plan Date Range **6-1-2007** to **5-31-2008** Meeting Date: **5-29-2007**

Individual's Name: **Pilsbury D Ohboy** Medicaid Number: **100000000099**

Does this individual live with Family? **No**

	Housemate Name(s) (if any)	Housemate's Case Manager (if any)	Housemate's Funding Source
#1	DooSco	Scrappy Doo	Other
#2	FlinFre	Barney Rubble	CHOICE
#3			

1. This team document outlines a typical week of planning toward the delivery and average # of needed **DAYS, BMGT, and/or RHSS** service hours as reflected within the Individualized Support Plan (ISP).
2. This document represents the team's agreement surrounding the needed delivery of these services.
3. **The actual # of needed service hours for this individual may vary from week to week.**
4. This document is not inclusive of all services the team may identify for this individual and will not be used for auditing purposes.

DAYS	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Weekly Total
Average # of Hours Per Day (excluding SEFA & SE)	5.3	0.0	6.8	0.0	3.5	0.0	0.0	15.50
Supported Employment Follow Along # of hours (if provided)	0.0	2.0	0.0	0.0	0.0	0.0	0.0	2.00
Sheltered Employment # of hours (if provided)	0.0	0.0	0.0	0.0	3.0	0.0	0.0	3.00

- **DAYS:** # of Days per year **Waived** 5 DAYS TOTAL: 151
- Is **Transportation** provided for this individual No
- Does **Transportation** need to be ADA accessible No

Behavioral Support Services	
Typical # of hours of Behavior Management (BMGT) provided monthly by the Behavioral Consultant <u>6.0</u>	
Respite Services	
Typical # of hours Respite provided monthly <u> </u>	

RHSS	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Weekly Total
Average # of Hours Per Day** (if provided)	12.0	8.0	12.0	8.0	12.0	18.0	18.0	88.00

****Please note that it would not be considered appropriate to enter 24 hours of service for each individual living in a home where staffing is shared.**

- **RHSS:** # of RHSS per year **Waived** 35 RHSS TOTAL: 330
- Is **Health Care Coordination** (by RN or LPN) being provided as a part of RHSS Yes
- Does this plan cover **24-hours of daily Paid Support** No
- Is **Transportation** provided for this individual Yes
- Does **Transportation** need to be ADA accessible No
- **RLA:** Monthly amount of Residential Living Allowance (RLA) \$ \$332

Individual's name:	<u>Pilsbury D Ohboy</u>
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DAYS Comments:

DAYS (Not SEFA nor SE) Comments: Consumer attends more hours in Winter months. He is often gone in summer months for vacation.

SEFA Comments: Consumer takes time off with employer in summer for vacation.

SE Comments: Consumer works 6 hours on Fridays during 6 months in the winter, and he works 0 hours during the 6 months of summer.

BMGT Comments:

BMGT Comments:

Respite Comments:

Respite Comments: Pilsbury uses all his Respite in summer months when out of school.

RHSS Comments:

RHSS Comments:

All team members will sign to signify their participation in development of this Interdisciplinary Team CCB Documentation and Service Agreement for the meeting held 5-29-2007.

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? **Consumer:**

Signature/Date

Printed Name

? **Guardian:**

Signature/Date

Printed Name

? **Parent:**

Signature/Date

Printed Name/Agency

? **Advocate:**

Signature/Date

Printed Name

? **DAYS Services:**

Signature/Date

Printed Name/Agency

? **RHSS Services:**

Signature/Date

Printed Name/Agency

? **Behavior Services:**

Signature/Date

Printed Name/Agency

? **Case Manager:**

Signature/Date

Printed Name

? **BDDS Service Coordinator:**

Signature/Date

Printed Name

? **Other Team Members:**

Signature/Date

Printed Name/Agency and/or Relationship

Signature/Date

Printed Name/Agency and/or Relationship

Signature/Date

Printed Name/Agency and/or Relationship

Signature/Date

Printed Name/Agency and/or Relationship